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APPLICATION NO.	FILING DATE	FIRST NAMED INVENTOR	ATTORNEY DOCKET NO.	CONFIRMATION NO.
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09/736,138

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Joane Goodroe

GOOD1 (11652.107070)

8196

7590

08/25/2006

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EXAMINER

PASS, NATALIE

ART UNIT

PAPER NUMBER

3626

DATE MAILED: 08/25/2006

Please find below and/or attached an Office communication concerning this application or proceeding.

<b>Office Action Summary</b>	<b>Application No.</b>		<b>Applicant(s)</b>	
	09/736,138		GOODROE ET AL.	
	<b>Examiner</b>		<b>Art Unit</b>	
	Natalie A. Pass		3626	

**-- The MAILING DATE of this communication appears on the cover sheet with the correspondence address --**

**Period for Reply**

A SHORTENED STATUTORY PERIOD FOR REPLY IS SET TO EXPIRE 3 MONTH(S) OR THIRTY (30) DAYS, WHICHEVER IS LONGER, FROM THE MAILING DATE OF THIS COMMUNICATION.

- Extensions of time may be available under the provisions of 37 CFR 1.136(a). In no event, however, may a reply be timely filed after SIX (6) MONTHS from the mailing date of this communication.
- If NO period for reply is specified above, the maximum statutory period will apply and will expire SIX (6) MONTHS from the mailing date of this communication.
- Failure to reply within the set or extended period for reply will, by statute, cause the application to become ABANDONED (35 U.S.C. § 133). Any reply received by the Office later than three months after the mailing date of this communication, even if timely filed, may reduce any earned patent term adjustment. See 37 CFR 1.704(b).

**Status**

- 1) ☒ Responsive to communication(s) filed on 17 February 2006.
- 2a) ☐ This action is **FINAL**.                      2b) ☒ This action is non-final.
- 3) ☐ Since this application is in condition for allowance except for formal matters, prosecution as to the merits is closed in accordance with the practice under *Ex parte Quayle*, 1935 C.D. 11, 453 O.G. 213.

**Disposition of Claims**

- 4) ☒ Claim(s) 2-19 and 24-27 is/are pending in the application.
- 4a) Of the above claim(s) \_\_\_\_\_ is/are withdrawn from consideration.
- 5) ☐ Claim(s) \_\_\_\_\_ is/are allowed.
- 6) ☒ Claim(s) 2-19 and 24-27 is/are rejected.
- 7) ☐ Claim(s) \_\_\_\_\_ is/are objected to.
- 8) ☐ Claim(s) \_\_\_\_\_ are subject to restriction and/or election requirement.

**Application Papers**

- 9) ☐ The specification is objected to by the Examiner.
- 10) ☐ The drawing(s) filed on \_\_\_\_\_ is/are: a) ☐ accepted or b) ☐ objected to by the Examiner.  
Applicant may not request that any objection to the drawing(s) be held in abeyance. See 37 CFR 1.85(a).  
Replacement drawing sheet(s) including the correction is required if the drawing(s) is objected to. See 37 CFR 1.121(d).
- 11) ☐ The oath or declaration is objected to by the Examiner. Note the attached Office Action or form PTO-152.

**Priority under 35 U.S.C. § 119**

- 12) ☐ Acknowledgment is made of a claim for foreign priority under 35 U.S.C. § 119(a)-(d) or (f).
- a) ☐ All    b) ☐ Some \*    c) ☐ None of:
1. ☐ Certified copies of the priority documents have been received.
2. ☐ Certified copies of the priority documents have been received in Application No. \_\_\_\_\_.
3. ☐ Copies of the certified copies of the priority documents have been received in this National Stage application from the International Bureau (PCT Rule 17.2(a)).

\* See the attached detailed Office action for a list of the certified copies not received.

**Attachment(s)**

- |   |   |
|---|---|
| 1) <input checked="" type="checkbox"/> Notice of References Cited (PTO-892)             | 4) <input type="checkbox"/> Interview Summary (PTO-413)                     |
| 2) <input type="checkbox"/> Notice of Draftsperson's Patent Drawing Review (PTO-948)    | Paper No(s)/Mail Date. _____  |
| 3) <input type="checkbox"/> Information Disclosure Statement(s) (PTO-1449 or PTO/SB/08) | 5) <input type="checkbox"/> Notice of Informal Patent Application (PTO-152) |
| Paper No(s)/Mail Date _____   | 6) <input type="checkbox"/> Other: _____                                    |

## **DETAILED ACTION**

### ***Notice to Applicant***

1. A request for continued examination under 37 CFR 1.114, including the fee set forth in 37 CFR 1.17(e), was filed in this application after final rejection. Since this application is eligible for continued examination under 37 CFR 1.114, and the fee set forth in 37 CFR 1.17(e) has been timely paid, the finality of the previous Office action has been withdrawn pursuant to 37 CFR 1.114. Applicant's submission filed on 17 February 2006 has been entered.

2. This communication is in response to the Request for Continued Examination and the amendments filed 17 February 2006. Claims 24-25 have been amended. Claims 1, 20-23 have been cancelled. Claim 27 has been newly added. Claims 2-19, 24-27 remain pending.

### ***Specification***

3. The objection to the specification under 35 U.S.C. 132, for introducing new matter, is hereby withdrawn due to the amendment filed 17 February 2006.

### ***Claim Rejections - 35 USC § 112***

4. The rejection of claims 25-26 under 35 U.S.C. 112, first paragraph is hereby withdrawn due to the amendment filed 17 February 2006.

### ***Claim Rejections - 35 USC § 101***

5. The rejection of claims 2-20, 24-26 under 35 U.S.C. 101 is hereby withdrawn due to the amendment filed 17 February 2006.

*Claim Rejections - 35 USC § 103*

6. The following is a quotation of 35 U.S.C. 103(a) which forms the basis for all obviousness rejections set forth in this Office action:

(a) A patent may not be obtained though the invention is not identically disclosed or described as set forth in section 102 of this title, if the differences between the subject matter sought to be patented and the prior art are such that the subject matter as a whole would have been obvious at the time the invention was made to a person having ordinary skill in the art to which said subject matter pertains. Patentability shall not be negated by the manner in which the invention was made.

7. Claims 3-7, 11-18, 24 are rejected under 35 U.S.C. 103(a) as being unpatentable over McCartney, U.S. Patent Number 5, 778, 345 in view of Dang, U.S. Patent Number 5, 835, 897 for substantially the same reasons given in the prior Office Action (paper number 04292005). Further reasons appear hereinbelow.

- (A) Claim 24 has been amended to include the recitation of
- a. “wherein the collected data is electronically stored in a database,” in lines 4-5;
  - b. “identifying from the collected data reduction opportunities for reducing waste and costs during the specific clinical procedures,” in lines 6-7; and
  - c. “the identified reduction opportunities,” in lines 8-9.

As per newly amended claim 24, McCartney teaches a computer-implemented method of increasing resource utilization efficiency and identifying areas to enhance quality (McCartney; Figure 1, column 6, lines 10-14), the method comprising the steps of:

collecting data “compiled during a patient’s visit or stay with a health care provider and is a record of the particulars thereof...” (reads on “related to a specific clinical procedure”) (McCartney; column 9, lines 15-29, column 12, lines 30-35), wherein the collected data is

Art Unit: 3626

electronically stored in a database (McCartney; Figure 3, Item 30, column 9, lines 39-43, column 13, lines 2-7);

identifying from the collected data “potential savings ... for various scenarios” (reads on “reduction opportunities for reducing waste and costs during the specific clinical procedures”) (McCartney; column 18, lines 34-48);

establishing a benchmark related to the specific “medical service” (reads on “clinical procedure”) based upon the identified reduction opportunities and at least a portion of the data (McCartney; column 12, lines 30-35, column 18, lines 38-48) and

McCartney fails to explicitly disclose standardizing the specific clinical procedure based upon the benchmark.

However, the above features are well-known in the art, as evidenced by Dang.

In particular, Dang teaches creating or engineering quality improvement protocols (reads on “standardizing”) said clinical procedure based upon said benchmark (Dang; column 19, lines 40-64, column 36, lines 15-19).

It would have been obvious to one of ordinary skill in the art at the time the invention was made to modify the method of McCartney to include these limitations, as taught by Dang, with the motivations of providing an objective means for measuring and quantifying health, care services (Dang; see at least Abstract).

(B) As per claims 3-7, McCartney and Dang teach a method as analyzed and discussed in claim 24 above

Art Unit: 3626

wherein said collecting step comprises determining resources used in said clinical procedure (McCartney; column 2, lines 56-58, column 3, lines 50-66, column 5, line 45 to column 6, line 39, column 9, lines 15-38);

wherein said establishing step comprises identifying resources to be used to establish said benchmark for said clinical procedure (McCartney; column 2, lines 56-58, column 3, lines 50-66, column 5, line 45 to column 6, line 39, column 12, lines 30-35, column 18, lines 17-49, column 21, lines 45-56);

wherein standardizing step comprises setting the quantity of at least one resource to be used for said clinical procedure while correlating the clinical outcome (Dang; column 7, lines 32-35, column 19, lines 40-64, column 36, lines 15-19);

further comprising the steps of accepting a request for said clinical procedure, and requesting resources to be utilized in said clinical procedure based upon said benchmark (Dang; column 4, lines 46-56, column 19, lines 40-64, column 36, lines 15-19); and

further comprising the steps of accepting a request for said clinical procedure, and allocating resources to said clinical procedure based upon said benchmark (McCartney; see at least Abstract, column 2, lines 56-58, column 3, lines 50-66, column 5, line 45 to column 6, line 39, column 12, lines 30-65, column 18, lines 17-49, column 21, lines 45-56).

The motivations for combining the respective teachings of McCartney and Dang are as given in the rejection of claim 24 above, and incorporated herein.

(C) As per claims 11-15, McCartney, and Dang teach a method as analyzed and discussed in claims 24 and 7 above

Art Unit: 3626

further comprising the step of compiling a report of resources utilization based upon said data (McCartney; see at least Figure 14, Item 670, Figure 16, Item 899, column 5, line 45 to column 6, line 39, column 9, lines 16-39, column 12, lines 6-16, column 16, lines 29-43, column 19, line 60 to column 20, line 7, column 21, line 45 to column 22, line 2);

wherein said report comprises a clinical outcomes report (McCartney; see at least Figure 14, Item 670, Figure 16, Item 899, column 5, line 45 to column 6, line 39, column 9, lines 16-39, column 12, lines 6-16, column 16, lines 29-43, column 19, line 60 to column 20, line 7, column 21, line 45 to column 22, line 2);

wherein said report comprises a procedure results report (McCartney; see at least Figure 14, Item 670, Figure 16, Item 899, column 5, line 45 to column 6, line 39, column 9, lines 16-39, column 12, lines 6-16, column 16, lines 29-43, column 19, line 60 to column 20, line 7, column 21, line 45 to column 22, line 2);

wherein said report comprises a patient profile report (Dang; column 5, lines 20-34, column 19, lines 18-23, column 6, lines 49-64); and

wherein said report comprises information on medication used during said clinical procedure (Dang; Figure 8C, column 6, lines 49-64, column 7, lines 23-30).

The motivations for combining the respective teachings of McCartney and Dang are as given in the rejection of claim 24 above, and incorporated herein.

(D) As per claims 16-18, McCartney, and Dang teach a method as analyzed and discussed in claims 24 and 11 above

Art Unit: 3626

wherein said report comprises information on the length of stay of patients undergoing said clinical procedures (McCartney; column 12, lines 30-35);

wherein said report comprises information on the demographics of patients undergoing said clinical procedure (McCartney; see at least Figure 8, column 5, line 45 to column 6, line 39, column 10, lines 51-65. column 11, lines 45-67, column 12, lines 56-56, column 14, lines 60-67); and

wherein said collecting step comprises monitoring the cost of said clinical procedure to provide a benchmark (McCartney; column 5, line 45 to column 6, line 39, column 12, lines 6-36, column 17, lines 60-62).

8. Claims 8-10, 19 are rejected under 35 U.S.C. 103(a) as being unpatentable over McCartney, U.S. Patent Number 5, 778, 345 in view of Dang, U.S. Patent Number 5, 835, 897 as applied to claims 24 and 7 above, and further in view of Jones et al., U.S. Patent Number 6, 117, 073 for substantially the same reasons given in the prior Office Action (paper number 04292005). Further reasons appear hereinbelow.

(A) As per claim 8, McCartney and Dang teach a method as analyzed and discussed in claims 24 and 7 above.

McCartney and Dang fail to explicitly disclose a method further comprising the step of verifying the existence of supplies in inventory.

However, the above features are well-known in the art, as evidenced by Jones.



In particular, Jones teaches verifying or tracking the existence of supplies in inventory (Jones; Figure 5b, Item 372, Figure 10, Item 920, column 3, lines 54-61, column 5, lines 6-20, column 10, lines 11-19, column 14, lines 5-20, column 17, lines 1-26).

It would have been obvious to one of ordinary skill in the art at the time the invention was made to modify the collective teachings of McCartney and Dang to include the step of verifying or tracking the existence of supplies in inventory, as taught by Jones, with the motivations of providing a comprehensive medical system that includes managing a clinical diagnosis and treatment and accurately billing the patient for the services rendered, as well as ensuring adequate supplies and equipment (Jones; see at least column 1, lines 30-32, column 1, line 65 to column 2, line 3, column 10, lines 11-18).

(B) As per claims 9-10 and 19, McCartney, Dang and Jones teach a method as analyzed and discussed in claims 24 and 7 above

further comprising the step of scheduling the requisitioning or restocking of supplies based upon said benchmark (Jones; Figure 8, Item 712, column 1, lines 61-64, column 3, line 63 to column 4, line 5, column 6, lines 13-21, column 10, lines 11-19, column 14, lines 5-20, column 17, lines 1-11);

further comprising the step of automatically ordering supplies from vendors based upon the needs of the clinical practice based upon said benchmark (Jones; column 3, line 54 to column 4, line 5, column 10, lines 10-19); and

Art Unit: 3626

wherein said collecting step comprises monitoring costs of requisitioned supplies (Jones; Figure 10, Item 920, column 2, lines 6-24, column 3, lines 54-61, column 5, lines 6-20, column 10, lines 11-19).

9. Claim 25 is rejected under 35 U.S.C. 103(a) as being unpatentable over McCartney, U.S. Patent Number 5, 778, 345 in view of Dang, U.S. Patent Number 5, 835, 897 for substantially the same reasons given in the prior Office Action (paper number 04292005), and further in view of article: Alba, T. et al. How hospitals can use internal benchmark data to create effective managed care arrangements. Journal of Health Care Finance. Fall 1994, hereinafter called Alba. Further reasons appear hereinbelow.

- (A) Claim 25 has been amended to include the recitation of
- a. "allocation of the resource and the conducted specific clinical procedure, wherein the collected data is electronically stored in a database," in lines 7-8;
  - b. "identifying from the stored data reduction opportunities for reducing waste and costs of the resource for the specific clinical procedure," in lines 11-12; and
  - c. "providing the standardization for the specific clinical procedure prior to conducting a subsequent specific clinical procedure, such that fewer resources are allocated," in lines 22-24.

Art Unit: 3626

As per newly amended claim 25, McCartney and Dang teach a computer-implemented method of increasing resource utilization efficiency and identifying areas to enhance quality (McCartney; Figure 1, column 6, lines 10-14), the method comprising the steps of:

allocating a resource for a specific clinical procedure (McCartney; column 2, lines 56-58, column 3, lines 50-66, column 6, lines 10-15, 30-39, column 9, lines 20-22, column 12, lines 56-65), (Dang; column 19, lines 40-64);

conducting the specific clinical procedure during which time at least of portion of the resource is utilized (McCartney; column 3, lines 55-65, column 9, lines 15-38);

collecting data related to the allocation of the resource and the conducted specific clinical procedure, wherein the collected data is electronically stored in a database (McCartney; Figure 3, Item 30, column 3, lines 15-18, column 6, lines 10-15, 30-39, column 9, lines 15-43, column 13, lines 2-7);

identifying from the stored data “potential savings ... for various scenarios” (reads on “reduction opportunities for reducing waste and costs of the resource for the specific clinical procedure” (McCartney; column 18, lines 34-48);

establishing a benchmark “dynamically” (reads on “based upon the identified reduction opportunities and the utilization of the resource”) (McCartney; column 18, lines 30-44); and

creating or engineering quality improvement protocols (reads on “standardizing”) the specific clinical procedure based upon the benchmark (Dang; column 19, lines 40-64, column 36, lines 15-19).

McCartney and Dang fail to explicitly disclose a method further comprising

Art Unit: 3626

the benchmark correlating to an average utilization of the resource for the specific clinical procedure; and

providing the standardization for the specific clinical procedure prior to conducting a subsequent specific clinical procedure, such that fewer resources are allocated.

However, the above features are well-known in the art, as evidenced by Alba.

In particular, Alba teaches a method further comprising

the benchmark correlating to an average utilization of the resource for the specific clinical procedure (Alba; page 2, paragraph 2, page 3, paragraph 9); and

providing the standardization for the specific clinical procedure prior to conducting a subsequent specific clinical procedure, such that fewer resources are allocated (Alba; paragraph bridging pages 4-5, page 5, paragraph 3, page 6, paragraphs 8-9).

It would have been obvious to one of ordinary skill in the art at the time the invention was made to modify the collective teachings of McCartney and Dang to include these limitations, as taught by Alba, with the motivations of enabling medical facilities that utilize process benchmarking to meet customer needs while meeting provider needs for maintaining a predictable profit margin (Alba, page 2, paragraph 1).

The motivations for combining the respective teachings of McCartney and Dang are as given in the rejection of claim 24 above, and incorporated herein.

10. Claim 26 is rejected under 35 U.S.C. 103(a) as being unpatentable over McCartney, U.S. Patent Number 5, 778, 345, Dang, U.S. Patent Number 5, 835, 897 and article, Alba, T. et al. How hospitals can use internal benchmark data to create effective managed care arrangements.

Art Unit: 3626

Journal of Health Care Finance. Fall 1994, hereinafter called Alba, as applied to claim 25 above, and further in view of article, "Cost Control Incented Many Ways Despite OIG Ruling on Gainsharing, "April 12, 2000, Physician Compensation Report, URL: <[http://www.findarticles.com/p/articles/mi\\_m0FBW/is\\_4\\_1/ai\\_61933228/print](http://www.findarticles.com/p/articles/mi_m0FBW/is_4_1/ai_61933228/print)>, hereinafter known as CostControl for substantially the same reasons given in the prior Office Action (paper number 04292005). Further reasons appear hereinbelow.

(A) As per claim 26, McCartney, Dang and Alba teach a method as analyzed and discussed in claim 25 above.

McCartney, Dang and Alba fail to explicitly disclose a method further comprising the step of rewarding physicians' efforts to reduce costs by providing a share of savings in response to utilizing the standardized specific clinical procedure.

However, the above features are well-known in the art, as evidenced by CostControl.

In particular, CostControl teaches a method further comprising the step of rewarding physicians' efforts to reduce costs by providing a share of savings in response to utilizing the standardized specific clinical procedure (CostControl; paragraphs 1-2, 5, 8-9).

It would have been obvious to one of ordinary skill in the art at the time the invention was made to modify the collective teachings of McCartney, Dang and Alba to include these limitations, as taught by CostControl, with the motivations of producing cost cutting incentives, such as those aimed at expenses each physician can control, and holding down costs under different formulas: some directed at group savings and others at individual savings; some aimed

Art Unit: 3626

at specific costs and others at overall costs; some tied to quality and some not (CostControl; see at least paragraphs 1-2).

11. Claim 2 is rejected under 35 U.S.C. 103(a) as being unpatentable over McCartney, U.S. Patent Number 5, 778, 345 in view of Dang, U.S. Patent Number 5, 835, 897 as applied to claim 24 above, and further in view of article, "Cost Control Incented Many Ways Despite OIG Ruling on Gainsharing, "April 12, 2000, Physician Compensation Report, URL: <[http://www.findarticles.com/p/articles/mi\\_m0FBW/is\\_4\\_1/ai\\_61933228/print](http://www.findarticles.com/p/articles/mi_m0FBW/is_4_1/ai_61933228/print)>, hereinafter known as CostControl for substantially the same reasons given in the prior Office Action (paper number 04292005). Further reasons appear hereinbelow.

(A) As per claim 2, McCartney and Dang teach a method as analyzed and discussed in claim 24 above.

McCartney and Dang fail to explicitly disclose a method further comprising the step of rewarding physicians' efforts to reduce costs by providing a share of savings in response to utilizing said standardized specific clinical procedure.

However, the above features are well-known in the art, as evidenced by CostControl.

In particular, CostControl teaches a method further comprising the step of rewarding physicians' efforts to reduce costs by providing a share of savings in response to utilizing said standardized specific clinical procedure (CostControl; paragraphs 1-2, 5, 8-9).

It would have been obvious to one of ordinary skill in the art at the time the invention was made to modify the collective teachings of McCartney and Dang to include these

Art Unit: 3626

limitations, as taught by CostControl, with the motivations of producing cost cutting incentives, such as those aimed at expenses each physician can control, and holding down costs under different formulas: some directed at group savings and others at individual savings; some aimed at specific costs and others at overall costs; some tied to quality and some not (CostControl; see at least paragraphs 1-2).

12. Claim 27 is rejected under 35 U.S.C. 103(a) as being unpatentable over McCartney, U.S. Patent Number 5, 778, 345 in view of Dang, U.S. Patent Number 5, 835, 897 as applied to claims 24 and 11 above, and further in view of Kessler et al., U.S. Patent Number 5, 324, 077.

(A) As per newly added claim 27, McCartney and Dang teach a method as analyzed and discussed in claims 24 and 11 above.

McCartney and Dang fail to explicitly disclose a method wherein the report comprises a report overlay presenting the established benchmark.

However, the above features are well-known in the art, as evidenced by Kessler.

In particular, Kessler teaches a method wherein the report comprises a report overlay (Kessler; Figure 3, column 5, lines 40-42, column 9, lines 43-45).

It would have been obvious to one of ordinary skill in the art at the time the invention was made to modify the collective teachings of McCartney and Dang to include these limitations, as taught by Kessler, with the motivations of adding “tremendous versatility” by accommodating “varying data recordation requirements,” and avoiding the necessity of a medical care provider maintaining a supply of many different forms (Kessler; column 9, lines 45-51, column 10, lines 2-20).

*Response to Arguments*

13. Applicant's arguments filed 17 February 2006 have been fully considered but they are not persuasive. Applicant's arguments will be addressed hereinbelow in the order in which they appear in the responses filed 17 February 2006.

(A) At pages 6-10 of the 17 February 2006 response Applicant points out support for newly added limitations in the originally filed specification in order to overcome objections to the specification under 35 U.S.C. 132 and rejections under 35 U.S.C. 112, first paragraph. Examiner thanks Applicant for these explanations, and has, accordingly, withdrawn the aforementioned.

(B) At pages 13- 14 of the 17 February 2006 response Applicant argues that the features in the Application are not taught or suggested by the applied references. In response, all of the limitations which Applicant disputes as missing in the applied references, including the newly added limitations of the amendment filed 17 February 2006, have been fully addressed by the Examiner as either being fully disclosed or obvious in view of the combined teachings of McCartney, Dang, Alba, CostControl Jones and Kessler, based on the logic and sound scientific reasoning of one ordinarily skilled in the art at the time of the invention, as detailed in the remarks and explanations given in the preceding sections of the present Office Action and in the prior Office Action (paper number 04292005), and incorporated herein. In particular, Examiner notes that the recited features of "establishing a benchmark related to the specific "medical



Art Unit: 3626

service” (reads on “clinical procedure”) based upon the identified reduction opportunities are taught by the combination of applied references. Please note that Examiner interprets McCartney's recitation of “... process is repeated for other resources ... [...] .... By recalculating budget information the potential savings resulting from achieving different benchmarks are calculated. This information about potential savings is key to decision making and the process of running the software for various scenario's marks this system an invaluable tool for health administrators and planners. ... [...] ... The benchmark ... [...] ... can be a predetermined value ... [...] ... or more preferably it can be dynamically computed ... [...] ... and then choosing ... the benchmark ... [...] ...” (emphasis added) (McCartney; column 18, lines 30-45) as teaching that the benchmark can be a predetermined value, or can be chosen after the identification of the reduction opportunities.

With regard to Applicant's assertion in paragraph 4 of page 13 of the 17 February 2006 response that "McCartney teaches away from the present invention," Examiner respectfully disagrees. Examiner interprets McCartney's recitation of “module 500 [service efficiency analysis module] can be selectively applied to current data ... [...] ...or to the future,” and “[t]he benchmark ... [...] ... can be a predetermined value ... [...] ... or more preferably it can be dynamically computed ... [...] ... and then choosing ... the benchmark ... [...] ...” (McCartney; column 18, lines 30-48) as teaching that in different embodiments the identification of the reduction opportunities can occur prior to the establishment of the benchmark or afterwards, and as such, the McCartney reference does not “teach away.”

***Conclusion***

14. The prior art made of record and not relied upon is considered pertinent to Applicant's disclosure. The cited but not applied references Waclawsky, et al., U.S. Patent Number 5, 446, 874, Abelow, U.S. Patent Number 5, 999, 908, Raposo, U.S. Patent Application Publication Number 2001/0049621, and the articles teach the environment of clinical operational management and creating benchmarks to help contain costs.

Maxwell, M. et al., Clinical benchmarking: results into practice. International Journal of Health Care Quality Assurance. Bradford: 1996. Vol.9, Iss. 4; pg. 20. [Proquest: Retrieved on August 14, 2006].

Awasthi V, et al. Providing Cost Data to Physicians Helps Contain Costs. Healthcare financial Management. Apr 96: 40-2. [Proquest: Retrieved on August 15, 2006].

Health Benchmarks, Inc. website. November, 1999. [Retrieved on August 15, 2006].  
Retrieved from Internet. URL:  
<<http://web.archive.org/web/19991129033505/http://www.healthbenchmarks.com/>>.

Kiefe, C. et al. Methodology Matters-XII. Identifying Achievable Benchmarks of Care: concepts and methodology. International Journal for Quality in Health Care 1998; 10(5): 443-7.

15. Any response to this action should be mailed to:

**Commissioner of Patents and Trademarks**

**Washington D.C. 20231**

or faxed to: **(571) 273-8300.**

For informal or draft communications, please label  
"PROPOSED" or "DRAFT" on the front page of the communication  
and do NOT sign the communication.

After Final communications should be labeled "Box AF."

16. Any inquiry concerning this communication or earlier communications from the examiner should be directed to Natalie A. Pass whose telephone number is (571) 272-6774. The examiner can normally be reached on Monday through Thursday from 9:00 AM to 6:30 PM. The examiner can also be reached on alternate Fridays.

17. If attempts to reach the examiner by telephone are unsuccessful, the examiner's supervisor, Joseph Thomas, can be reached at (571) 272-6776. Any inquiry of a general nature or relating to the status of this application or proceeding should be directed to the Receptionist whose telephone number is (571) 272-3600.

18. Information regarding the status of an application may be obtained from the Patent Application Information Retrieval (PAIR) system. Status information for published applications may be obtained from either Private PAIR or Public PAIR. Status information for unpublished applications is available through Private PAIR only. For more information about the PAIR system, see <http://pair-direct.uspto.gov>. Should you have questions on access to the Private PAIR system, contact the Electronic Business Center (EBC) at 866-217-9197 (toll-free).



Natalie A. Pass

August 15, 2006



C. LUKE GILLIGAN  
PATENT EXAMINER